

The preparation, submission, and implementation of the Plan of Corrections does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all state and federal regulatory requirements. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

F - 657 - SS=D - 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision :

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Resident #46 had a clarification of Nutritional / Dietary needs correction made on 4/23/19, by IDT; includes ED, DON, Therapy, MDS, RD.
 - B. Care plan revised related the clarification order completed on 4/23/19, by MDS.
 - C. Education with the clinical staff, Therapy, MDS presented on 4/23/19, by SDC
Ongoing education to be completed by 6/3/19 with SDC.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Identification and Audit completed on 4/23/19 of all residents that have modified or alternative diets, by RD.
 - B. Care plan revisions completed as indicated by audit on 4/23/19, by MDS.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Licensed clinical staffs were in-serviced by 4/23/19 on the requirements of the care plan, Kardex, communication and how to make changes when indicated. Initial in- services on the care plan, Kardex, communication and how to make changes when indicated. Completed on 4/24/19 with all other indicated staff receiving in - service by Staff Development Coordinator and IDT.
 - B. IDT and MDS to review nutrition careplans weekly to ensure ongoing compliance.

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4. Monitoring of corrective action to ensure the effectiveness of the education
 - A. Unit Managers will review the physician orders daily Monday thru Friday for 4 weeks(weekends reviewed Monday) and then 3 times weekly for 8 weeks and review findings with clinical team (DON, UM or designee) as indicated.
 - B. MDS will review orders daily and document changes Monday thru Friday for 8 weeks and report any necessary changes to the clinical team daily.
 - C. Findings will be reported to the DON,ED who will take appropriate action if needed.
 - D. Failure to adhere to facility requirement will result in re-education
 - E. Report of findings will be reported to the facility Quality Assurance Committee (QAPI) for a period of 8 weeks to review the need for continued intervention or amendment of plan- team includes: DON,ED, Dietary, Therapy, MDS, Housekeeping, Plant ops. (all department leaders)

COMPLETION DATE 6/3/2019

F 658 - SS=D 483.21(b)(3)(i) Services Provided Meet Professional Standards

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Resident #46 had a clarification of Nutritional / Dietary needs correction made on 4/23/19, by IDT: includes ED, DON, Therapy, MDS, RD.
 - B. Care plan revised related the clarification order completed on 4/23/19, by MDS.
 - C. Education with the clinical staff, Therapy, MDS presented on 4/23/19, by SDC. Ongoing education to be completed by SDC on 6/3/19.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Identification and Audit completed on 4/23/19 of all residents that have modified or alternative diets.
 - B. Care plan revisions completed as indicated by audit on 4/23/19, By MDS.

3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Licensed clinical staff were in-serviced by 4/23/19 on the requirements of the care plan, Kardex, communication and how to make changes when indicated. Initial in- services completed on 4/24/19 with all other indicated staff receiving in – service by Staff Development Coordinator and IDT.
 - B. IDT and MDS to review weekly to ensure ongoing compliance.
4. Monitoring of corrective action to ensure the effectiveness of the education:
 - A. Unit Managers will review the physician orders daily Monday thru Friday for 4 weeks (weekends will be reviewed Monday)and then 3 times weekly for 8 weeks and review findings with clinical team as indicated.
 - B. MDS will review orders daily and document changes Monday thru Friday for 8 weeks and report any necessary changes to the clinical team daily.
 - C. Findings will be reported to the Director of Nursing who will take appropriate action if needed.
 - D. Failure to adhere to facility requirement result in re-education.
 - E. Report of findings will be reported to the facility Quality Assurance Committee for a period of 8 weeks to review the need for continued intervention or amendment of plan.
5. COMPLETION DATE 6/3/2019

F 842 - SS = D 483.20(f)(5), 483.70(i)(1)-(5) Resident Records – Identifiable Information

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Resident #18 had a clarification of Advance Directive / POLST correction made on 4/23, by IDT.
 - B. Care plan revised related the clarification order completed on 4/23/19, by MDS
 - C. Education with the clinical staff, Therapy, MDS presented on 4/23/19, by SDC. Ongoing education to be completed by 6/3/19, by SDC.

2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Identification and Audit completed on 4/23/19 of all residents Advance Directive / POLST, by IDT: includes ED, DON, Therapy, MDS, RD, Medical records
 - B. Medical Records revisions completed as indicated by audit on 4/23/19, by Medical records.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. licensed clinical staff were in-serviced by 4/23/19 on the requirements of the Advance Directive / POLST, physician orders, care plan, communication and how to make changes when indicated. Initial in- services completed on 4/24/19 with all other indicated staff receiving in – service by Staff Development Coordinator and IDT.
 - B. Review Advance Directives / POLST weekly to ensure ongoing compliance by Medical Records and the IDT.
4. Monitoring of corrective action to ensure the effectiveness of the education:
 - A. Unit Managers will review the physician orders daily Monday thru Friday for 4 weeks (weekends will be reviewed on Monday)and then 3 times weekly for 8 weeks and review findings with clinical team as indicated.
 - B. MDS will review orders daily and document changes Monday thru Friday for 8 weeks and report any necessary changes to the clinical team daily.
 - C. Medical records will complete audits daily Monday thru Friday for 8 weeks and obtain or clarify Advance Directive / POLST as indicated.
 - D. Findings will be reported to the Director of Nursing who will take appropriate action as needed.
 - E. Failure to adhere to facility requirement result in re-education.
 - F. Report of findings will be reported to the facility Quality Assurance Committee for a period of 8 weeks to review the need for continued intervention or amendment of plan.
5. COMPLETION DATE 6/3/2019

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45th day / 70th
6-8-19 / 7-3-19

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION POC#1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445512	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2019
NAME OF PROVIDER OR SUPPLIER NASHVILLE CENTER FOR REHABILITATION AND HEALING LL			STREET ADDRESS, CITY, STATE, ZIP CODE 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000			
F 657 SS=D	<p>A recertification survey was completed on 4/24/19 at Nashville Center for Rehabilitation and Healing. Deficiencies were cited related to the recertification survey under 42 CFR PART 483, Requirements for Long Term Care Facilities.</p> <p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <ul style="list-style-type: none"> (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- <ul style="list-style-type: none"> (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. <p>This REQUIREMENT is not met as evidenced by:</p>	F 657			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	<p>Continued From page 1</p> <p>Based on facility policy review, medical record review and interview, the facility failed to revise and update a care plan for 1 resident (#46) of 52 residents reviewed.</p> <p>The findings include:</p> <p>Review of facility policy, Care Plans-Comprehensive revised September 2010 revealed "...Assessments of residents are ongoing care plans are revised as information about the resident and the resident's condition change...The care planning/Interdisciplinary Team is responsible for the review and updating of care plans...When there has been a significant change in the resident's condition...When the desired outcome is not met...When the resident has been re-admitted to the facility from a hospital stay...At least quarterly..."</p> <p>Medical record review revealed Resident #46 was admitted to the facility on 3/5/19 and re-admitted on 4/12/19 with diagnoses which included Cognitive Communication Deficit and Dysphagia.</p> <p>Medical record review of Resident #46's Physician Order Summary Report dated 4/12/19 revealed "...Consistent CHO [carbohydrate] diet mechanically altered ground texture, Nectar consistency...4/16/19 ST [Speech Therapy] downgrade patient to total feed for all meals to maximize PO [by mouth] intake and decrease weight loss..."</p> <p>Medical record review of Resident #46's 5 day Minimum Data Set dated 4/8/19 revealed the resident required extensive assistance with eating.</p>	F 657			

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F 657	<p>Continued From page 2</p> <p>Medical record review of Resident #46's Speech Therapy Encounter Note dated 4/16/19 revealed "...Patient downgraded to total feed with staff educated on swallow strategies..."</p> <p>Medical record review of Resident #46's kardex (aide care plan), undated, revealed "...Eating: (0/1) Independent and Setup help needed..."</p> <p>Medical record review of Resident #46's Daily Skilled Nursing Flowsheet dated 4/16/19 revealed "...total assistance needed for eating and drinking..."</p> <p>Observation on 4/23/19 at 8:15 AM and on 4/24/19 at 8:37 AM in Resident #46's room revealed the resident in bed with an untouched breakfast tray on the bedside table in front of the resident.</p> <p>Interview with Certified Nurse Aide (CNA) #1 on 4/24/19 at 8:55 AM in the family lounge revealed CNA #1 did not have residents which required assistance with meals. Continued interview revealed Resident #46 only needed cues during meals.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 4/24/19 at 10:29 AM in the family lounge revealed, staff set up Resident #46's meal trays and the resident would feed himself. Continued interview revealed "...it's more of an encouragement..." than providing assistance.</p> <p>Interview with Registered Nurse #1 on 4/24/19 at 1:08 PM in her office confirmed Resident #46 required total assistance with all meals. Continued interview revealed "...once we get the order we can update the kardex..." Continued</p>	F 657			

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F 657	Continued From page 3 interview confirmed "...theoretically the kardex needed to be updated as soon as the order comes through..."	F 657			
F 658 SS=D	<p>Interview with the Director Of Nursing on 4/24/19 at 1:23 PM in her office when asked to review Resident #46's kardex she confirmed it wasn't updated to reflect total dependence with meals. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to follow physician orders to provide total assistance with meals for 1 resident (#46) of 52 residents reviewed.</p> <p>The findings include:</p> <p>Medical record review revealed Resident #46 was admitted to the facility on 3/5/19 and re-admitted on 4/12/19 with diagnoses which included Cognitive Communication Deficit and Dysphagia.</p> <p>Medical record review of Resident #46's Physician Order Summary Report dated 4/12/19 revealed "...Consistent CHO [carbohydrate] diet mechanically altered ground texture, Nectar consistency...4/16/19 ST [Speech Therapy] downgrade patient to total feed for all meals to maximize PO [by mouth] intake and decrease weight loss..."</p>	F 658			

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F 658	Continued From page 4 Medical record review of Resident #46's 5 day Minimum Data Set dated 4/8/19 revealed the resident required extensive assistance with eating. Medical record review of Resident #46's Speech Therapy Encounter Note dated 4/16/19 revealed "...Patient downgraded to total feed with staff educated on swallow strategies..." Medical record review of Resident #46's kardex (aide care plan), undated, revealed "...Eating: (0/1) Independent and Setup help needed..." Medical record review of Resident #46's Daily Skilled Nursing Flowsheet dated 4/16/19 revealed "...total assistance needed for eating and drinking..." Observation on 4/23/19 at 8:15 AM and on 4/24/19 at 8:37 AM in Resident #46's room revealed the resident in bed with an untouched breakfast tray on the bedside table in front of the resident. Interview with Certified Nurse Aide (CNA) #1 on 4/24/19 at 8:55 AM in the family lounge revealed CNA #1 did not have residents which required assistance with meals. Continued interview revealed Resident #46 only needed cues during meals. Interview with Licensed Practical Nurse (LPN) #2 on 4/24/19 at 10:29 AM in the family lounge revealed, staff set up Resident #46's meal trays and the resident would feed himself. Continued interview revealed "...it's more of an encouragement..." than providing assistance.	F 658			

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F 658	Continued From page 5	F 658			
	Interview with Registered Nurse #1 on 4/24/19 at 1:08 PM in her office confirmed Resident #46 required total assistance with all meals.				
	Interview with the Director Of Nursing on 4/24/19 at 1:23 PM in her office confirmed the physician's orders for Resident #46 were not followed related to meal assistance.				
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842			

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F 842	<p>Continued From page 6</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 842			

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F 842	<p>Continued From page 7</p> <p>Based on facility policy review, medical record review and interview, the facility failed to maintain an accurate and complete record for 1 resident (#18) of 52 residents reviewed related to the Physician Orders and Physician Orders For Life Sustaining Treatment/Physician Orders for Scope of Treatment (POLST/POST) form not matching.</p> <p>The findings include:</p> <p>Review of the facility policy, Advance Directives-MOLST (Medical Orders For Life Sustaining Treatment) / POLST (Physician Orders For Life Sustaining Treatment), undated, revealed "...Residents of the facility will have their advance directives [including MOLST and POLST] honored...These will be reviewed upon admission and periodically throughout their stay...MOLST/POLST is a medical order form that tells others the resident's/patient's wishes regarding life-sustaining treatment...It is designed to communicate the individual's wishes about a range of life-sustaining and resuscitative measures...It is a portable, valid and immediately actionable medical order consistent with the individual's wishes and current medical condition, which will be honored across treatment settings...The MOLST/POLST form is legally sufficient and recognized as a medical order...The order will be added to the resident's admitting orders...If "Do Not Resuscitate [DNR]" is indicated on the MOLST/POLST, the facility will follow procedure for communication and documentation of the DNR..."</p> <p>Medical record review revealed Resident #18 was admitted to the facility on 2/7/19 with diagnoses which included Chronic Obstructive Pulmonary Disease and Kidney Transplant Status.</p>	F 842			

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F 842	<p>Continued From page 8</p> <p>Medical record review of Resident #18's Admission Minimum Data Set dated 2/14/19 revealed the resident had a Brief Interview of Mental Status Score of 12 indicating the resident was moderately cognitively impaired. Further review revealed the resident makes self understood and understand others.</p> <p>Medical record review of Resident #18's POST/POLST form dated 2/12/19 revealed "...the resident was to be resuscitated, meaning to perform Cardiopulmonary Resuscitation (CPR) if the resident had no pulse and was not breathing..."</p> <p>Medical record review of Resident #18's Physician Order Summary dated 2/12/19 revealed "...MOLST: Do Not Resuscitate (DNR)..."</p> <p>Medical record review of Resident #18's comprehensive care plan dated 2/7/19 with revision on 2/17/19 revealed "...Resident has advanced directive of DNR...Resident Advance Directives will be regarded and respected...Properly label medical records and follow Advance Directives..."</p> <p>Interview with Licensed Practical Nurse #1 on 4/23/19 at 10:00 AM at the 600 Hall nurse station revealed when a resident codes (has no pulse and is not breathing) staff go to the chart and look at the POST form to determine whether the resident is full code (requiring CPR) or DNR. Continued interview revealed the resident's code status was also recorded on the resident's physician orders.</p>	F 842			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445512	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2019
NAME OF PROVIDER OR SUPPLIER NASHVILLE CENTER FOR REHABILITATION AND HEALING LL			STREET ADDRESS, CITY, STATE, ZIP CODE 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 842	<p>Continued From page 9</p> <p>Interview with the 600 Hall Unit Manager on 4/23/19 at 10:20 AM at the 600 Hall nurse station confirmed if a resident codes, staff were to look at the POST form in the resident's chart and verify it with the physician order. Continued interview when asked to review Resident #18's POLST/POST form and Physician Order Summary she stated "these should match and they don't."</p> <p>Interview with the Director of Nursing on 4/23/19 at 10:23 AM in her office revealed the resident's POST form declares the resident resuscitation status. Continued interview revealed, "once the declaration is confirmed the order is written and would match the POST form." Continued interview when asked to review Resident #18's POST form and Physician Order Summary confirmed the POST form and orders for Resident #18 did not match.</p>	F 842			

May 10, 2019

Donna Smith, RN
Public Health Regional Regulatory Program Manager
Middle Tennessee Regional Office, Health Care Facilities

Dear Mrs. Smith,

Please accept the following as our (Nashville Center for Rehabilitation and Healing – TN1938) plan of correction resulting from the survey conducted April 22, 2019- April 24, 2019. Included is the signed and dated 2567 as well as the plan of correction (12 pages) in the newly allowed formatting of full page documentation. Should anything further be needed please let me know and I will gladly and expediently provide.

On a side note – Happy Nurses Week to you and all nurses!

Best,



Roger Peden II
Administrator

Nashville Center for Rehabilitation and Healing
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Nashville, Tn 37203
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2019
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OMB NO. 0938-0391

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E 000	Initial Comments An emergency preparedness survey was completed on 4/24/19 at Nashville Center for Rehabilitation and Healing. No deficiencies were cited under FED-E-1.00.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.